

# Waiting List Exception Request

Date:						
Client N						
S#:	DOB:		Tier:			
CM:		TCM Phone:				
/ledicai	•	plication:				
not el	igible for Medicaid, please explain why:					
1.	Which crisis definition applies to this situation? (Please m					
	Requires protection from confirmed abuse, neglect, or exploitation or written documentation of pending action for same (Please provide supporting documentation)					
	Perram Q access to cause (, reace browned on blow m Q ac					
	DCF currently involved?	□ Yes	□ No			
	Police/Court currently involved?	🗆 Yes	🗆 No			
	Medical Specialist currently involved?	🗆 Yes	🗆 No			
2.	Are there current significant Behavioral/Mental Health Ne Explain:	eeds?	□ Yes	□ No		
	Are Behavioral/Mental Health Services in place?		□ Yes	🗆 No		
	Provider :					
	Services:					
	Is there a current Behavioral Support Plan?		□ Yes	🗌 No		
	Are these needs being met? If not, why:		🗆 Yes	🗆 No		
3.	Are there current significant Medical Needs? Diagnosis		□ Yes	🗆 No		
	Are these needs being met? If not, why:		□ Yes	🗆 No		
	Can these needs be met through EPSDT? If not, wh	y:	□ Yes	🗆 No		

4. What Services are being requested:

IN-HOME SUPPORT				
What are the current support system				
<ul> <li>□ Parents at home</li> <li>□ Parents c</li> <li>□ Friends</li> <li>□ Church</li> </ul>	-		•	
☐ Friends ☐ Church ☐ Medical Supports (in home care/l	□ Family			
			unded Support:	
Are In-Home Support current		$\Box$ Yes	□ No	
Who is the provider:				
What has changed:				
what has changed.				
DAY SERVICES				
What are the current day activities:				
□ School/Education	🗆 Employment	🗆 Volunteer Oppor	Volunteer Opportunities	
Mental Health Services	Medical Services	🗆 Private Pay I/DD	Private Pay I/DD Services	
Recreational Activities	□ Other:			
Are Day Services currently be	ing provided:	□ Yes	🗆 No	
	01			
What has changed:				
Have employment options be	an avalarad2 If not why:	🗆 Yes	🗆 No	
Is there an open Vocational F	Rehabilitation case?	🗆 Yes	□ No	
<b>RESIDENTIAL SERVICES</b>				
What are the current living arranger	nents:			
Lives in own home alone	$\Box$ Lives in own hom	ne with others		
□ Lives with parents/family/friend	Homeless			
Lives in foster home placement	•	setting/nursing home		
Other:				
Does the individual currently have al	pility to pay room and board?	□ Yes	🗆 No	
If not, why:		When:		
Why are current living arrangement	s no longer able to meet the ne	ed.		
Terminally ill/significant health iss	-	cu.		
□ Confirmed for abuse, neglect or e	xploitation			
□ Placed in nursing facility/assisted	-			
□ Incarceration				
$\Box$ No longer willing/able to provide :	supports			
□ Inability to continue private pay s				
□ CDDO no longer able to fund supp	oorts/services			
□ Other:				

## 5. What other community resources have been explored prior to making this request (Check all that apply)?

Other HCBS Waivers	$\Box$ Mental Health Services	Parsons Outreach Team
MCO Value Added Benefits	Local Family Support Grants	🗆 EPSDT
Private Insurance	🗌 Vocational Rehab	DCF Programs
Educational Programs	🗌 After School Care	🗌 CDDO State Aid
Independent Living Skills Services	Other:	

#### 6. Persons living in the home:

Name	Relationship	Age	Employed	

## 7. Gross Monthly Income:

SSI/SSDI	\$ Employment	\$
Family Support/Subsidy	\$ Alimony/Child Support	\$
Cash Assistance	\$ Trust Fund Payments	\$
Adoption Subsidy	\$ Food Stamps	\$
Other	\$ Explain Other	
	Monthly Income	\$
	Annual Income	\$

## 8. Gross Monthly Expenses:

Mortgage/Rent	\$ Electric/Gas	\$
Phone	\$ Cable	\$
Water/Trash	\$ Alimony/Child Support	\$
Food Transportation (payment, gas,	\$ Laundry	\$
insurance)	\$ Childcare	\$
Insurance	\$ Savings	\$
Retirement/Investments	\$	
Other	\$ Explain Other:	
	Total Monthly Expenses	\$
	Annual Expenses	\$

9. What is the immediate negative outcome if the service is not approved?

**10.** Please summarize the request for exception with any additional detail the funding committee should be aware of related to this request? This includes any barriers to placement (family, financial, behavioral)

I \_\_\_\_\_\_ authorize my case manager to submit this request for funding

#### (person/guardian)

to the CDDO & Kansas Department for Aging and Disability Services. The CDDO of Butler County will review the request and supporting documentation within 3 business days and determine if all other community supports have been exhausted prior to making a possible recommendation to KDADS.

If/When the request is forwarded to KDADS, they have 10 business days to follow up with additional questions and make a determination on the exception to services. If KDADS has determined an approval to bypass the waiting list and access I/DD Waiver Services, they will inform the parent/guardian via mail.

The Managed Care Organization (MCO) managing the Medicaid Card will contact the parent/guardian to complete a Needs Assessment to determine the HCBS services which will be approved. Once services have been approved, the parent/guardian will need to contact the CDDO of Butler County to complete Options Counseling/Provider Choice choosing the providers in our area for the services.